In the United States Court of Federal Claims

OFFICE OF SPECIAL MASTERS

No. 08-0469V

Filed: September 23, 2013

Not to be Published

SYRITTA D. MITCHELL, legal representative of minor child, Jayden Bradford,	*	
	*	Autism; Statute of Limitations;
	*	Untimely Filed.
v.	*	
Petitioner,	*	
	*	
SECRETARY OF HEALTH AND HUMAN SERVICES,	*	
	*	
Respondent.	*	

DECISION[1]

On June 26, 2008, Petitioner, Syritta Mitchell, filed a petition for Vaccine Compensation in the National Vaccine Injury Compensation Program ("the Program"),[2] alleging that the autism condition of her son, Jayden Bradford, was caused by a series of Hemophilus influenza type B polysaccharide conjugate (hereinafter "Hib") vaccines administered on February 10, 2004, April 13, 2004, June 22, 2004, and March 15, 2005.

On May 4, 2010, the parties requested that I rule on the issue of whether this petition was *timely filed*. (See my Order filed May 5, 2010.) However, as noted in my Order of June 15,

[1] Because this unpublished decision contains a reasoned explanation for the action in this case, I intend to post this decision on the United States Court of Federal Claims' website, in accordance with the E-Government Act of 2002, Pub. L. No. 107-347, § 205, 116 Stat. 2899, 2913 (codified as amended at 44 U.S.C. § 3501 note (2006)). In accordance with Vaccine Rule 18(b), petitioner has 14 days to identify and move to delete medical or other information, the disclosure of which would constitute an unwarranted invasion of privacy. If, upon review, I agree that the identified material fits within this definition, I will delete such material from public access.

[2] The Program comprises Part 2 of the National Childhood Vaccine Injury Act of 1986, Pub. L. No. 99-660, 100 Stat. 3755, codified as amended, 42 U.S.C. §§ 300aa-10 *et seq.* (hereinafter "Vaccine Act" or "the Act"). Hereafter, individual section references will be to 42 U.S.C. § 300aa of the Act.

2011, in order to rule on that issue I was required to await a relevant ruling of the United States Court of Appeals for the Federal Circuit in *Cloer v. HHS*.

On February 7, 2013, I issued an order stating that in light of the *Cloer* decision (654 F. 3d 1302), the parties would have 30 days to supply me with any additional arguments concerning the timeliness issue. Neither party filed additional arguments. Accordingly, the timeliness issue is now ripe for a ruling.

I

BACKGROUND -- THE OMNIBUS AUTISM PROCEEDING

This case concerning Jayden Bradford is one of more than 5,000 cases filed under the Program in which it has been alleged that a child's disorder known as "autism," or a similar disorder, was caused by one or more vaccinations. A brief summary of the proceedings conducted with respect to those 5,000 cases is relevant to this Decision.

In anticipation of dealing with this large group of cases involving a common factual issue--*i.e.*, whether vaccinations can cause autism--the Office of Special Masters ("OSM") devised special procedures. On July 3, 2002, the Chief Special Master, acting on behalf of the OSM, issued a document entitled the Autism General Order # 1, 4 which set up a proceeding known as the "Omnibus Autism Proceeding" (OAP). In the OAP, a group of counsel selected from attorneys representing petitioners in the autism cases, known as the Petitioners' Steering Committee ("PSC"), was charged with obtaining and presenting evidence concerning the general issue of whether those vaccines can cause autism, and, if so, in what circumstances. The evidence obtained in that general inquiry was to be applied to the individual cases. (Autism General Order # 1, 2002 WL 31696785, at *3, 2002 U.S. Claims LEXIS 365, at *8.)

Ultimately, the PSC elected to present two different theories concerning the causation of autism. The first theory alleged that the measles portion of the MMR vaccine can cause autism, in situations in which it was alleged that thimerosal-containing vaccines previously weakened an infant's immune system. That theory was presented in three separate Program "test cases," during several weeks of trial in 2007. The second theory alleged that the mercury contained in the thimerosal-containing vaccines can directly affect an infant's brain, thereby substantially contributing to the development of autism. The second theory was presented in three additional "test cases" during several weeks of trial in 2008.

On February 12, 2009, decisions were issued concerning the three "test cases" pertaining to the PSC's first theory. In each of those three decisions, the petitioners' causation theories were rejected. I issued the decision in *Cedillo v. HHS*, No. 98-916V, 2009 WL 331968 (Fed. Cl. Spec. Mstr. Feb. 12, 2009). Special Master Patricia Campbell-Smith issued the decision in *Hazlehurst v. HHS*, No. 03-654V, 2009 WL 332306 (Fed. Cl. Spec. Mstr. Feb. 12, 2009). Special Master Denise Vowell issued the decision in *Snyder v. HHS*, No. 01-162V, 2009 WL 332044 (Fed. Cl. Spec. Mstr. Feb. 12, 2009).

Those three decisions were later each affirmed in three different rulings, by three different judges of the U.S. Court of Federal Claims. *Hazlehurst v. HHS*, 88 Fed. Cl. 473 (2009); *Snyder v. HHS*, 88 Fed. Cl. 706 (2009); *Cedillo v. HHS*, 89 Fed. Cl. 158 (2009). Two of those three rulings were then appealed to the U.S. Court of Appeals for the Federal Circuit, again resulting in affirmances of the decisions denying the petitioners' claims. *Hazlehurst v. HHS*, 604 F. 3d 1343 (Fed. Cir. 2010); *Cedillo v. HHS*, 617 F. 3d 1328 (Fed. Cir. 2010).

On March 12, 2010, the same three special masters issued decisions concerning three separate "test cases" pertaining to the petitioners PSC's second causation theory. Again, the petitioners' causation theories were rejected in all three cases. *King v. HHS*, No. 03-584V, 2010 WL 892296 (Fed.Cl.Spec.Mstr. Mar. 12, 2010); *Mead v HHS*, No. 03-215V, 2010 WL 892248 (Fed.Cl.Spec.Mstr. Mar. 12, 2010); *Dwyer v. HHS*, No. 03-1202V, 2010 WL 892250 (Fed.Cl.Spec.Mstr. Mar.12, 2010). None of the petitioners elected to seek review any of those three decisions.

II

PROCEDURAL HISTORY

On June 26, 2008, Syritta D. Mitchell (Petitioner), as legal representative of her minor child, Jayden Bradford ("Jayden"), filed a petition for compensation under the National Childhood Vaccine Injury Act of 1986. (Pet.) Petitioner filed some medical records, designated as Exhibits 1 through 9, along with her petition. On that same day, the case was assigned to Special Master Abell. (Notice, ECF No. 2.)

On August 19, 2008, Respondent filed a Report requesting that additional medical records be filed. (Report at 1.) On November 10, 2008, Petitioner filed a Motion for Leave to Subpoena Medical Records, which was granted by Special Master Abell. (Motion and Order, ECF Nos. 6, 7.) On November 14, 2008, the court issued an Order directing Petitioner to file, by January 23, 2009, all medical records and relevant fact witness affidavits. Petitioner thereafter filed on March 16, 2009, a set of Supplemental Exhibits 1-2 (ECF No. 12).

On June 3, 2009, Respondent filed a set of Interrogatories on Petitioner. (ECF No. 16.) On July 10, 2009, Petitioner filed Answers to the interrogatories. ("Answers," ECF No. 18.)

On May 4, 2010, the parties requested that I rule on the issue of whether the petition was *timely filed*. (See my Order filed May 5, 2010.) However, as noted in my Order of June 15, 2011, in order to rule on that issue I was required to await a relevant ruling of the United States Court of Appeals for the Federal Circuit in *Cloer v. HHS*.

On February 7, 2013, I issued an order stating that in light of the *Cloer* decision (654 F. 3d 1302), the parties would have 30 days to supply me with any additional arguments concerning the timeliness issue. Neither party filed additional arguments. Accordingly, the timelinesss issue is now ripe for a ruling.

III

FACTUAL HISTORY

Jayden Bradford was born on December 1, 2003, in Oakland, California. (Ex. 1,[3] p. 1.) Jayden was the product of an uneventful pregnancy, was healthy at birth, and was found to be a normally developing child at two "well baby" pediatrician visits when he was evaluated by pediatrician Careen Whitley, M.D. (Ex. 2 pp. 1-3 [well baby visits of December 8, 2003 and January 12, 2004].)

Beginning on February 10, 2004, Jayden received his first Hib vaccination, and thereafter received the rest of the Hib series on April 13, 2004, June 22, 2004, and March 15, 2005. (Ex. 3 p. 1.)

On February 10, 2004, April 13, 2004, June 22, 2004, August 3, 2004, December 21, 2004, March 14 ,2005, July 12, 2005, and December 19, 2005, Jayden had well baby pediatrician visits with Dr. Whitley and continued to develop normally. (*See generally* Ex. 4.)

Petitioner stated, in her answers to Respondent's interrogatories, that between December 1, 2004, and June 1, 2005, when Jayden was 12 to 18 months old, "***his behavior took a downward spiral. He started to display over the top tantrums. He was kinda zoned out most of the time. Wasn't interested in play activities with anyone. No interest in age appropriate toys." (Answers, pp. 1-2.) Petitioner's answers commented repeatedly upon Jayden's change in behavior during this time period when he was 12 to 18 months of age. Petitioner stated:

> I know some time between 12-18 months * * * he wasn't interested anyone or anything that required him to interact with anyone. I can remember walking right pass [sic] him to leave the house and he didn't even move as to try and leave with me or even cry as most children do when a parent is leaving them behind. He preferred to sit and spin objects for the most part, or open and close things if there were a door on it." (Answers, p. 2.)

Specifically, in response to one interrogatory when Respondent asked Petitioner if Jayden ever "lost" language, Petitioner stated, "I feel Jayden lost the ability to use language. He seemed to be on track before the age of 1. * * * [but] shortly after turning 1, he didn't speak at all until he was almost 3 years old." (Answers, p. 5.)

[3] Petitioner filed Exhibits 1 through 9 with her petition on June 26, 2008, to which I will refer as "Ex. __."

On August 8, 2006, Jayden had a well-baby visit where he was examined by Kathryn Malone, MD, who wrote that she was "[c]oncerned about developmental delay. Will refer to Children's Hospital for evaluation." (Ex. 5, p. 1.)

On September 11, 2006, Jayden presented to Molly Walker, M.S., who is a Speech/Language Pathologist, who wrote (Ex. 6, p. 4):

> Jayden, a 2 year 9 month old child, present with significantly delayed receptive and expressive language skills. He experienced difficulty participating in activities in this setting today. His family reports that this is an accurate picture of Jayden's behavior. Secondary to limited expressive language and compliance with tasks, an oral motor evaluation and articulation evaluation were not completed. It is recommended that the areas continue to be monitored as Jayden's language develops.

It is further noted in Jayden's "communication history" from this visit that Jayden's mother asserted that Jayden "did not frequently vocalize as an infant, however, "does babble." (Ex. 6, p. 1.) Reportedly, Jayden said his first word at age 1 and began using two-word combinations at age 2. (*Id.*)

On November 28, 2006, Jayden had a follow-up visit with Dr. Malone, who noted that "[w]ork up is being completed. I suspect possible autism." (Ex. 7 at 1.)

On August 27, 2007, at Jayden's well baby visit, he was examined by Dr. Whitley. Dr. Whitley indicated that the reason for the visit was "Infantile Autism-Active" and that Jayden was "dx'd [diagnosed] as autistic Dec. 2006." (Exhibit 9 at 1.)

IV

DIAGNOSTIC CRITERIA FOR AUTISM SPECTRUM DISORDERS

No evidence concerning the diagnostic criteria for autism spectrum disorders was filed by the parties in this case. Accordingly, I have relied upon the information set forth below in this Section IV of this Decision, which is drawn from OAP test case testimony provided by three pediatric neurologists with considerable experience in diagnosing ASDs. I further note that the information in this section was first compiled and published by my colleague, Special Master Vowell, in *White v. HHS,* 04-337V, 2011 WL 6176064 (Fed. Cl. Spec. Mstr. Nov. 22, 2011).

"The terms 'autism' and 'autism spectrum disorder' have been used to describe a set of developmental disorders characterized by impairments in social interaction, impairments in verbal and non-verbal communication, and stereotypical restricted or repetitive patterns of behavior and interests." (*Cedillo,* 2009 WL 331968, at *7 (Fed. Cl. Spec. Mstr. Feb. 12, 2009) (an OAP "test case.")) The specific diagnostic criteria for ASD are found in the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 4th ed. text revision

2000 ("DSM-IV-TR"),[4] the manual used in the United States to diagnose dysfunctions of the brain. (*See* testimony in *Cedillo* ("*Cedillo* Tr.") at 1278A.6) The manual identifies the behavioral symptoms recognized by the medical profession at large as symptoms of ASD.7 The DSM-IV-TR contains specific diagnostic criteria for autistic disorder, Asperger's disorder, and pervasive developmental disorder-not otherwise specified (most frequently referred to as ("PDD-NOS")). It is not uncommon for parents and even health care providers to use these terms in non-specific ways, such as referring to a child as having an "autism diagnosis," even though the specific diagnosis is PDD-NOS. Of note, a child's diagnosis within the autism spectrum may change from autistic disorder to PDD-NOS (or vice versa) over time.

A. Diagnosing Autism Spectrum Disorders

The behavioral differences in autism spectrum disorders encompass not only delays in development, but also qualitative abnormalities in development. (*Cedillo* Tr. at 1264A, 1589-91.) There can be wide variability in children with the same diagnosis. One child might lack language at all, while another with a large vocabulary might display the inability to engage in a non-scripted conversation. (*Cedillo* Tr. at 1602A-1604.) However, both would have an impairment in the communication domain.

Testing for the presence of an ASD involves the use of standardized lists of questions about behavior directed to caregivers and parents, as well as observations of behaviors in standardized settings by trained observers. (*Cedillo* Tr. at 1272A-74A.) One behavioral symptom alone, such as hand-flapping, would not be diagnostic of an ASD, but if present, it would be a symptom that would be part of the diagnostic picture. As one expert explained, in diagnosing an ASD, "we try to observe symptoms, and when we have observed enough symptoms, then we see if the child meets these criteria." (*Cedillo* Tr. at 1278A-79; *see also* testimony in the *King* OAP test case ("*King* Tr.") at 3253-54 (describing diagnostic instruments and their use in clinical settings); *King*, 2010 WL 892296.)

Typically in children with autism spectrum disorders, the symptoms have been present for weeks or months before parents report them to health care providers. (*Cedillo* Tr. at 1283.) The most common age at which parents recognize developmental problems, usually problems in communication or the lack of social reciprocity, is at 18-24 months of age. (*King* Tr. at 3259-60.) The development of symptoms of an ASD occurs very gradually, and it is not uncommon for the parents to be unable to date the onset very precisely. (*Cedillo* Tr. at 1285A-1286A.)

[4] I am aware that the American Psychiatric Association has recently released the *fifth* edition of the DSM. It is true that the DSM-V has somewhat revised the diagnostic criteria to pertaining to Autism Spectrum Disorders. However, based upon my review of this revision to the DSM, it appears that the symptoms discussed in this decision still clearly were the first symptoms of the onset of Jayden Bradford's ASD.

1. Autistic Disorder (Autism)

A diagnosis of autistic disorder requires a minimum of six findings from a list of impairments divided into three domains of impaired function: (1) social interaction; (2) communication; and (3) restricted, repetitive, and stereotyped patterns of behavior, interests, and activities. At least two findings related to social interaction and at least one each in the other two domains are required for diagnosis. To meet the diagnostic criteria for autism, the child must have symptoms consistent with six of the twelve listed types of behavioral impairments. Furthermore, the abnormalities in development must have occurred before the age of three. (*Cedillo* Tr. at 1264A, 1279, 1618; *King* Tr. at 3250.) Although the majority of children with autism have developmental delays, many are of normal intelligence. (*Cedillo* Tr. at 1276; *King* Tr. at 3256.) In testimony in the *Cedillo* OAP test case, one expert described the three domains as the "core features" of a diagnosis on the autism spectrum. (*Cedillo* Tr. at 1589-92.) Children with autism are most symptomatic in the second and third years of life. (*Cedillo* Tr. at 1618.)

2. Pervasive Developmental Disorder-Not Otherwise Specified

The DSM-IV-TR defines PDD-NOS as "a severe and pervasive impairment in the development of reciprocal social interaction," coupled with impairment in either communication skills or the presence of stereotyped behaviors or interests. (DSM-IV-TR at 84.) The diagnosis is made when the criteria for other autism spectrum disorders, or other psychiatric disorders, such as schizophrenia, are not met. (*Id.*) It includes what has been called "atypical autism," which includes conditions that present like autistic disorder, but with onset after age three, or which fail to meet the specific diagnostic criteria in one or more of the domains of functioning. (*Id.*) As was noted in the *Dwyer* OAP test case, this is the most prevalent of the disorders on the autism spectrum. (*Dwyer*, 2010 WL 892250, at *30.)

3. Asperger's Disorder

Asperger's syndrome is a form of high-functioning autism. It presents with significant abnormalities in social interaction and with restricted, repetitive, and stereotyped patterns of behavior, interests, and activities. (*See* DSM-IV-TR at 84.)

B. The Domains of Impairment and Specific Behavioral Symptoms

1. Social Interaction Domain

This domain encompasses interactions with others. (*Cedillo* Tr. at 1264A.) There are four subgroups within this domain. (*Id.* at 1594.) The subgroups include: (1) a marked impairment in the use of nonverbal behavior, such as gestures, eye contact and body language; (2) the failure to develop appropriate peer relations; (3) marked impairment in empathy; and (4) the lack of social or emotional reciprocity. (*Id.* at 1594-96.) To be diagnosed with autism (autistic disorder), the patient must have behavioral symptoms from two of the four subgroups. (*Id.* at 1594.) For an Asperger's diagnosis, there must be two impairments in this domain as well. (DSM-IV-TR at 84.) Children who do not display "the full set of symptoms" are diagnosed with PDD-NOS.

(*Cedillo* Tr. at 1275A.) Symptoms used to identify young children with impairments in the social interaction domain include lack of eye contact, deficits in social smiling, lack of response to their name, and the inability to respond to others. (*Cedillo* Tr. at 1269A-70A.)

One expert described the degrees of impairment in interactions with others as a continuum, with affected children ranging from socially unavailable to socially impaired. A child who is socially unavailable may exhibit such behaviors as failing to seek consolation after injury or purposeless wandering, or may simply appear isolated. (*Cedillo* Tr. at 1598.) A less impaired child might be socially remote, responding to an adult's efforts at social interaction, but not seeking to continue the contact. This child might roll a ball back and forth with an adult, but will not protest when the adult stops playing. (*Cedillo* Tr. at 1599.) Given a choice between playing with peers and playing by himself, a child with impairments in social interaction will play by himself. (*Id.*) Some children with ASD demonstrate socially inappropriate interactions, such as pushing other children in an effort to interact. (*Cedillo* Tr. at 1600.) A higher functioning child might attempt interaction, but does so as if reading from a script. As an example, Dr. Wiznitzer discussed a patient who, when asked where he lived, could not answer, but responded appropriately when Dr. Wiznitzer asked the child for his address. (*Id.* at 1601.)

2. Communication Domain

The communication domain involves both verbal and non-verbal communication, such as intonation and body language. (*Cedillo* Tr. at 1263, 1602A.) Language abnormalities in ASD encompass not only delays in language acquisition, but the lack of capacity to communicate with others. (*Id.* at 1267A.) Impaired communication abilities are one of the "most important and early recognized symptoms" of autism. (*Dwyer,* 2010 WL 892250 at *31.)

There are four criteria within the communication domain. (*Cedillo* Tr. at 1602A.) They include: (1) a delay in or lack of development in spoken language, without the use of signs or gestures to compensate; (2) problems in initiating or sustaining conversation; (3) stereotypic or repetitive use of language, including echolalia and repeating the script of a video or radio presentation, such as singing a commercial jingle; and (4) the lack of spontaneous imaginative or make-believe play. (*Cedillo* Tr. at 1602A-05.)

Language delay, limited babbling, lack of gestures, lack of pointing to communicate things other than basic wants and desires (lack of "protodeclarative" vs. "protoimperative" pointing), are all early symptoms used to diagnose impairments in the communication domain. (*Cedillo* Tr. at 1266A-68A.) One expert described the failure to share discoveries via language in autistic children as well. (*Cedillo* Tr. at 1606A.) Children with ASD who have more developed language skills may display difficulties in social communication outside their limited area of interest. (*Id*. at 1607.)

Within the communication domain, children with ASD have difficulties in joint attention, which one expert described as sharing an action or activity with another person or even an animal. They have problems with what he called metalinguistic skills, referring to the meaning behind the language used, which may be conveyed by tone, body language, humor, or sarcasm.

Children with ASD may understand visual humor, illustrated by the cartoon of an anvil falling on the coyote's head, but lack the ability to understand a joke. (*Cedillo* Tr. at 1607-09.) They focus on the literal, rather than figurative, meaning of words: telling a child with ASD to "hop to it" may elicit hopping, rather than an increase in speed in completing a task. These children use language primarily for getting their needs met. (*Id*. at 1609.) A child with ASD might lead a parent to the cookie jar, but would not lead a parent to a caterpillar crawling along the sidewalk.

Children with ASD often have impairments in specific types of play. They may understand cause and effect play, but have difficulties in imitative or representational play. They can push a button to make a toy figure pop up, but have difficulty with holding a tea party, putting a stuffed animal to bed, or feeding a doll. (*Cedillo* Tr. at 1610-11.) They also have impairments in symbolic play, in which an object such as a stick represents another object, such as a magic wand or sword. (*Id*. at 1612.) Speech and language delays are the symptoms most commonly reported by parents as a concern leading to a diagnosis of ASD. (*See Cedillo* Tr. at 1284 (one of first concerns noted by parents is the lack of language development); *King* Tr. at 3253 (problems in social and communication domains tend to be observed much earlier than stereotyped behaviors.))

A deficit in at least one of the subgroups in the communication domain is required for an autism diagnosis. (*Cedillo* Tr. at 1602A-1603.) An Asperger's diagnosis does not require communication domain impairment. (*Id.* at 1275A-76.) A PDD-NOS diagnosis requires an impairment in either this domain or the patterns of behavior discussed next. (*Id.* at 1592.)

3. Restricted, Repetitive and Stereotyped Patterns of Behavior Domain

There are four categories within this domain. They include (1) a preoccupation with an interest that is abnormal in intensity or focus, such as spinning a plate or a wheel or developing an intense fascination with a particular interest, such as dinosaurs, cartoon characters, or numbers; (2) an adherence to nonfunctional routines or rituals, such as eating only from a blue plate, sitting in the same seat, or walking the same route; (3) stereotypic or repetitive motor mannerisms, such as finger flicking, hand regard, hand flapping, or twirling; and (4) a persistent preoccupation with parts of an object, such as focusing on the wheel of a toy car and spinning it, rather than playing with the toy as a car. (*Cedillo* Tr. at 1613A-15, 1271A-72A.)

As one expert explained, this domain reflects abnormalities in the way play skills develop, as well as repetitive and rigid behavior. (*Cedillo* Tr. at 1264A.) A typical toddler may flick a light switch a few times, but the child with ASD performs the same action to excess. (*Cedillo* Tr. at 1616.) Another expert described one child who would not turn right; to make a right turn at a crossroads, he would have to make three left turns. (*King* Tr. at 3252-53.)

For a diagnosis of autism, a child must display behaviors in at least one of the categories included in this domain. (*Cedillo* Tr. at 1613A.) An Asperger's diagnosis also requires at least one behavioral impairment encompassed in this domain. (*Id.* at 1275A-76.) A PDD-NOS diagnosis requires either an impairment in this domain or an impairment in the communication domain. (*Id.* at 1592.)

C. Summary

The OAP evidence establishes that a diagnosis of ASD is based on observations of behavioral symptoms. The symptoms are categorized into three domains. For a definitive diagnosis of autism, the child must display behavioral abnormalities in each of the domains, and must exhibit at least six of the 12 behavioral criteria in the three domains. There must be at least two behaviors encompassed in the social interaction domain, reflecting the importance of impaired social interaction in diagnosing ASD. The behavioral abnormalities must manifest before the age of three.

Thus, the absence of any specific symptom would not rule out the diagnosis, so long as the requisite numbers of impairments in each domain of functioning are present. Conversely, autism cannot be diagnosed by any single abnormal behavior, but the ultimate diagnosis is based on an accumulation of symptomatic behaviors. The existence of any one behavioral abnormality associated with autism is sufficient to trigger the running of the statute of limitations.

For a diagnosis of Asperger's disorder, the child must display behavioral abnormalities similar to those of children with autistic disorder, but need not have a language abnormality. (*Cedillo* Tr. at 1275A-76; *see also* DSM-IV-TR at 84 (requiring two impairments in social interaction and one in restricted, repetitive, and stereotyped patterns of behavior, interests, and activities for this diagnosis.))

For a PDD-NOS diagnosis, the child must display behavioral abnormalities in all three domains. However, this diagnosis is given when the impairments fall short of the criteria required for a diagnosis of autism (autistic disorder). (*Cedillo* Tr. at 1275A.)

V

LEGAL STANDARD

The Vaccine Act provides that:

> a vaccine set forth in the Vaccine Injury Table which is administered after October 1, 1988, if a vaccine-related injury occurred as a result of the administration of such vaccine, no petition may be filed for compensation under the Program for such injury after the **expiration of 36 months** after the date of the occurrence of the first symptom or manifestation of onset or of the significant aggravation of such injury…

(§ 300aa-16(a)(2) (emphasis added)). In *Cloer v. HHS*, 654 F. 3d 1322 (Fed. Cir. 2011),[5] the

[5] The *Cloer* case recently was appealed to the United States Supreme Court, but only regarding the *attorneys' fees and costs* component of timeliness cases. The Supreme Court's resulting opinion is *not* relevant to the issues at hand in this case. *See Sebelius v. Cloer*, 133 S. Ct. 1886 (2013).

Court of Appeals for the Federal Circuit affirmed that the "statute of limitations begins to run on a specific statutory date: the date of occurrence of the first symptom or manifestation of onset of the vaccine-related injury recognized as such by the medical profession at large." (654 F.3d at 1340.) The date of the occurrence of the first symptom or manifestation of onset "does not depend on when a petitioner knew or reasonably should have known" about the injury. (*Id.* at 1339.) Nor does it depend on the knowledge of a petitioner as to the cause of the injury. (*Id.* at 1338.)

VI

ANALYSIS OF THE CASE

As noted above, §16(a)(2) requires that a Program petition, alleging injury by a vaccination administered after October 1, 1988, must be filed within 36 months after the date of the "first symptom or manifestation of the onset" of the injury in question. In this case, the petition was filed on June 26, 2008, so that if the first symptoms of Jayden's autism occurred prior to June 26, 2005, then the petition was not timely filed. However, as discussed earlier, speech and language delay is a recognized symptom of autism. (*See* Section IV above; *see also White v. HHS*, 04-337V, 2011 WL 6176064 (Fed. Cl. Spec. Mstr. Nov. 22, 2011) (the Special Master concluded that although not sufficient by itself to establish a diagnosis of autism, speech and language delay can constitute the first symptom or manifestation of onset of autism).) And, clearly, Jayden displayed his first symptoms of speech, language, and behavioral delay between the ages of 12 and 18 months (December 1, 2004 through June 1, 2005). First, Petitioner responded to Respondent's interrogatories by stating, "[b]etween the age of 12-18 months [*i.e.*, between December 1, 2004, and June 1, 2005] his behavior took a downward spiral. He started to display over the top tantrums. He was kinda zoned out most of the time. Wasn't interested in play activities with anyone. No interest in age appropriate toys." (Answers, pp. 1-2.) Petitioner responded to multiple interrogatories by citing to Jayden's change in behavior between the ages of 12 and 18 months. Petitioner stated:

> I know some time between 12-18 months alone he wasn't interested anyone or anything that required him to interact with anyone. I can remember walking right pass him [sic] to leave the house and he didn't even move as to try and leave with me or even cry as most children do when a parent is leaving them behind. He preferred to sit and spin objects for the most part, or open and close things if there were a door on it. (Answers, p. 2.)

Further, in response to an interrogatory in which Respondent asked Petitioner if Jayden ever "lost" language, Petitioner responded by stating that, "I feel Jayden lost the ability to use language. He seemed to be on track before the age of 1. Able to repeat and remember language and shortly after turning 1, he didn't speak at all until he was almost 3 years old." (Answers, p. 5.)

In sum, while Jayden clearly displayed the first symptoms of his autism between December 1, 2004, and June 1, 2005, the petition in this case was not filed until more than three years thereafter, on June 26, 2008. Accordingly, this case was not timely filed.

VII

CONCLUSION

I have great sympathy for the tragic disorder from which Jayden suffers. Under the applicable law, however, Petitioner has the burden to show timely filing. Petitioner has failed to do so. There is preponderant evidence that this case was not filed within "36 months after the date of the occurrence of the first symptom or manifestation of onset or of the significant aggravation of such injury" as required by the Vaccine Act, § 16(a)(2). **Therefore, this claim is dismissed as untimely filed under the Vaccine Act's statute of limitations.** §16(a)(2). **The clerk is directed to enter judgment accordingly.**

_____

George L. Hastings, Jr.
Special Master